

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015046

STATE FILE NUMBER 2 3897  
Registrar's No.

XC-2095 558

SL 19277

FILED MAY 6 1959

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before) a. STATE MISSOURI b. COUNTY SAINTE GENEVIEVE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO.		c. CITY OR TOWN ST. MARYS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		d. STREET ADDRESS (If outside, give location) ROUTE #1	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM C. GRIFFITH		4. DATE OF DEATH Month Day Year APRIL 18, 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/91
9. AGE (In years last birthday) 68		10. F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) BELGIQUE, MISSOURI		12. CITIZEN OF WHAT COUNTRY? USH	
13a. FATHER'S NAME WILLIAM GRIFFITH		13b. MOTHER'S MAIDEN NAME THEODOSIA BURNE	
14. NAME OF HUSBAND OR WIFE -----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES		16. SOCIAL SECURITY NO. NN-1	
17. INFORMANT VA HOSP. RECORDS, ST. LOUIS, MO.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE - SEPTAL MYOCARDIAL INFARCTION			INTERVAL BETWEEN ONSET AND DEATH 24 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) POST-OPERATIVE LEFT THORACO ABDOMINO EXPLORATION DUE TO (c) TION			560.4
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) DIAPHRAGMATIC HERNIA - HYPO PARA THYROIDISM			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. <input checked="" type="checkbox"/> attended the deceased from 3/3/59 to 4/18/59 and last saw him alive on 4/18/59 Death occurred at 9:35 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE E. EGO-AGUIRRE (Degree or title) M.D.		22b. ADDRESS VAH, ST. LOUIS, MO.	
		22c. DATE SIGNED 4/19/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4-20-59	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) St. Marys, Mo.	
24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. APR 20 '59	
26. REGISTRAR'S SIGNATURE Kearl Smith, M.D. mbs.			

All diseases in Part I must be causally related.  
 Doctor, coroner, etc. must use only standard nomenclature in their report. No symptoms with no test.  
 operation for hernia

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

300  
1-57

833-2-12  
88-1-12

DEC 8 1959

DEC 22 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ..... Student Embalmer No. .... working under my personal supervision.

Student .....

Signed *Elmer R. Caldwell*

Signature of Student Embalmer

Licensed Embalmer No. *4077*

P. O. Address *St. Louis, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.